AMANI TRUST

Beating your opposition.
Torture during the 2002 Presidential campaign in Zimbabwe.

A report and a dossier of cases prepared by the
Mashonaland Programme of the AMANI Trust.

25 June 2002

1. The AMANI Trust

The AMANI Trust is a Zimbabwean NGO, whose vision is the provision of medical, psychological and social assistance to victims of Organised Violence and Torture (OVT). Apart from the important rehabilitation work of the Trust, it also works for the elimination of torture both locally and internationally. The Trust was formed in 1993, but had previously existed as an ad hoc committee to implement the recommendations of the ground-breaking Conference on the "*Consequences of Organised Violence in Southern Africa*", held in Harare in 1990. This ad hoc committee, operating under the auspices of the Psychiatric Association of Zimbabwe, attempted to maintain regional collaboration on the issue of organised violence, and held a number of regional workshops and seminars. The name of the Trust, *AMANI*, meaning *peace* in Swahili, was given to this first initiative under the Psychiatric Association of Zimbabwe, and was formalised when the Trust was registered in 1993.

The Trust did initial work in the refugee camps for Mozambican refugees, training health and other workers in the identification and management of psychological disorders due to trauma. The first major programme initiated by the Trust, however, was a partnership with hospitals in Mount Darwin District. This began in 1995 and continued up to 2000. The work in Mount Darwin led to the development of a community-based rehabilitation model, that was shown to be effective and appreciated by the Ministry of Health and Child Welfare. The reputation of this programme then allowed AMANI to begin a programme in Matabeleland in 1997, and a separate programme was fully established in 1998. Both the Mashonaland and Matabeleland Programmes revolved around community-based approaches to rehabilitation, although there were regional differences in the approaches due to the difference in the two contexts.

The AMANI Trust began new work in 1998 in the aftermath of the Food Riots in January of that year. The new work, in the partnership with the then-formed Zimbabwe Human Rights NGO Forum, focused upon current as opposed to historical victims of torture. This required new skills and new approaches, and the Trust then developed a new model revolving around a medico-legal model. The Zimbabwe Human Rights NGO Forum has subsequently become an established feature of the human rights landscape, and has, together with the AMANI Trust, has led the field in documenting and reporting upon gross human rights violations.

The AMANI Trust continued its relationship with the Ministry of Health and Child Welfare with a new training programme for trauma counsellors. Two major training programmes were run during 1999 for Mashonaland Central Province, and, in 2000, on a national basis with trainees drawn from 6 of the Provinces. This was then extended in 2001 with the development of a forensic nurse examiner training programme, run jointly by AMANI and the Zimbabwe Nurses Association. This was done on a national basis, with nurse trainees being drawn from all Provinces. This course, which was the second of its kind in Africa was supported by the International Association of Forensic Nurses, and resulted in 22 diplomates graduating and the creation of the future pool of forensic nurse trainers.

Internationally, the AMANI Trust has acquired a reputation for expertise in the field of documentation and rehabilitation of torture survivors. The Trust is a long-standing member of the Danish-based International Rehabilitation Council for Torture Victims (IRCT), with representation on the Council since 1993, and membership of the Executive Committee of the Council since 2000. The Trust was also a founder member of the Southern African Trauma Coalition, an alliance of Southern African centres dealing with torture victims, having members in Namibia, South Africa and Zimbabwe. Staff from the AMANI Trust have participated in international missions in Botswana, the Philippines, Namibia, Nigeria, Malawi, Mozambique, Swaziland, and Zambia.

The Trust has an international reputation for its work, having published papers in scientific journals, produced a large number of reports and manuals, and made a large number of presentations at international conferences. In Zimbabwe, the Trust can reliably be regarded as expert on the matter of organised violence and torture, and has testified as such to the Commission to Investigate the War Victims Compensation Fund, the Chidyausiku Commission. The AMANI Trust was commended by the Commission for the utility of its submission and the supporting documents.

2. Organised violence and torture: an overview

Torture clearly represents an extreme form of exposure to violence, in that the effects are premeditated and designed, the process usually involves attacks of both a physical and psychological nature, and, most importantly, torture has an explicitly political purpose in a clear socio-political context. Torture may be divided into different kinds, but usually it is very difficult to separate them, and certainly it is common for different kinds of torture to be given at the same time. For example, it is very common for people to be given beatings at the same time that they are being verbally abused or threatened. Here there are two kinds of torture at the same time: physical torture in the form of beatings and psychological torture in the form of abuse and threats.

The definition of torture contained in the United Nations Convention Against Torture is a four-part definition as follows:

1. Severe **pain and suffering**, whether physical or mental;
2. **Intentionally** inflicted;
3. With a **purpose**;
4. By a state official or another acting with the **acquiescence** of the State.

This definition is widely used by health professionals in the diagnosis of torture, and is the basis for the examination of torture victims outlined in the Istanbul Protocol, which is now the standard protocol for examination of torture victims accepted by the United Nations High Commission for Human Rights.

2.1 Physical methods of torture

Beatings of one kind or another are by far the most common methods of abuse. The beatings can be generally all over the body, but some countries show a preference for a particular kind of beating. Falanga, or beating the soles of the feet, has been frequently reported in Middle Eastern countries, but there are reports of its use in African countries too. Electrical torture is popular because of the extreme pain that it causes, as well as the few scars that it leaves. Perpetrators in fact can use almost anything to abuse people. The point to grasp here is that any physical harm caused deliberately is torture, and thus any procedure or object can become torture or be used in torture.

2.2 Deprivation as torture

Deprivation is separated from psychological torture in the Southern African setting because it happens very frequently that people are detained in circumstances that lead to ill treatment, but where the intention is not to deliberately use the detention as torture. For the victim however the effect of the deprivation can be the same as torture. The point here is that torture is not just a matter of what was in the mind of the perpetrator or the person doing the detention, but it is also a question of what the victim believed was happening.

This is not an exclusive list, but it covers the kinds of treatments that are forbidden by most human rights conventions or conventions relating to the treatment of prisoners or detainees. These can be very difficult to assess in many African countries where the above forms of ill treatment are so common as to be felt that they are "normal" methods of treating prisoners. Patients will frequently be so used to these methods, or know that they are routinely practiced, so that they will not remark upon them for themselves.

2.3 Sensory over-stimulation

Sensory stimulation is frequently used as a method of torture by perpetrators, but it does not seem to be so common in community settings. The aim behind sensory stimulation, which is often erroneously termed "brain washing", is to attack the person in another way.

Psychological studies of sensory deprivation have clearly demonstrated the damaging effects of such abuse. For example, people subjected to constant "white noise" rapidly show signs of stress and can even begin to hallucinate if it goes on long enough.

All of these can be used deliberately, or can be part of the background to detentions. For example, many people have been tortured in settings where they can hear the sounds of others being tortured too, and will talk about how terrible it was to hear the screams and voices of their comrades. This could have been a deliberate policy on the part of the torturers, but is frequently due to their indifference to whether others can hear or not.

2.4 Psychological methods of torture

It is very rare to find physical torture unaccompanied by psychological torture, and psychological torture is probably the most common form of torture used. Psychological torture is also frequently applied on its own, and can be very successful in causing both short-term and long-term damage to a person. Psychological torture is not to be seen as a lesser form of ill treatment, because its consequences can very powerful and very long lasting.

2.5 High War Zone Stress & Witnessing violence

Some earlier workers in the field of traumatic stress argued that civilian populations were little affected by war. However, there was little direct investigation of trauma in civilian populations until the last decade, and, following the invention of PTSD, there has been the continual demonstration of psychological disorder in populations in situations of war and civil conflict. These situations are usefully described by the term "High War Zone Stress". The term was originally applied in a military context, to differentiate soldiers in combat settings from those in non-combat zones. It was defined by reference to frequent experience of military fighting, proximity to people being killed, and fears about oneself being killed. This situation is, of course, not unique to military personnel, and describes the daily life of many non-combatants and ordinary people. It is particularly relevant to situations of guerrilla war, and obviously to Southern Africa.

As originally propounded, High War Zone Stress refers to the situation that soldiers can find themselves in, whether they are professional soldiers or conscripts, and here we are referring to men generally who receive training. However, the term can also be applied to civilians, and it is worth remembering that up to 80% of the casualties of modern wars are civilians. Modern wars are distinguished by the strategic involvement of civilians, and especially where there are civil war situations and guerrilla warfare. So it is very common for ordinary civilians to find themselves in situations of high war stress, and to have the frequent experience of witnessing violence and death. Deliberate massacres and executions are frequently forced upon ordinary people by military and paramilitary forces in an attempt to remove support for guerrillas or political parties. Civilians are deliberately terrorized, threatened, and abused in order to destroy the support for one force or political party. This frequently leads to both sides terrorizing civilians in order to prevent support for the other side. For example, during the Liberation War in Zimbabwe it was common for the government security forces to attack villages and to kill or assault villagers in order to destroy support for the guerrillas, and it was also common for the guerrillas to undertake punitive actions against suspected supporters of the government. This creates a situation of sustained fear and stress for the ordinary person.

2.6 Disappearances

One very sinister form of deliberately inducing a situation of High War Zone Stress is the use of forced disappearances. This refers to the abduction of individuals, who may be kept in secret detention for long periods, but are often executed in secret. This is a strategy that has been growing in recent decades, and some of the most tragic examples can be found in Latin America. For example, about 40 000 individuals were "disappeared" in Argentina during the rule of the military junta in the 1970's. It is also a strategy used in Zimbabwe, both during the Liberation War and the Matabeleland emergency of the 1980's.

In Africa, disappearances may have even more profound effects. Since death and misfortune are always events of extreme concern for the entire extended family, a disappearance that

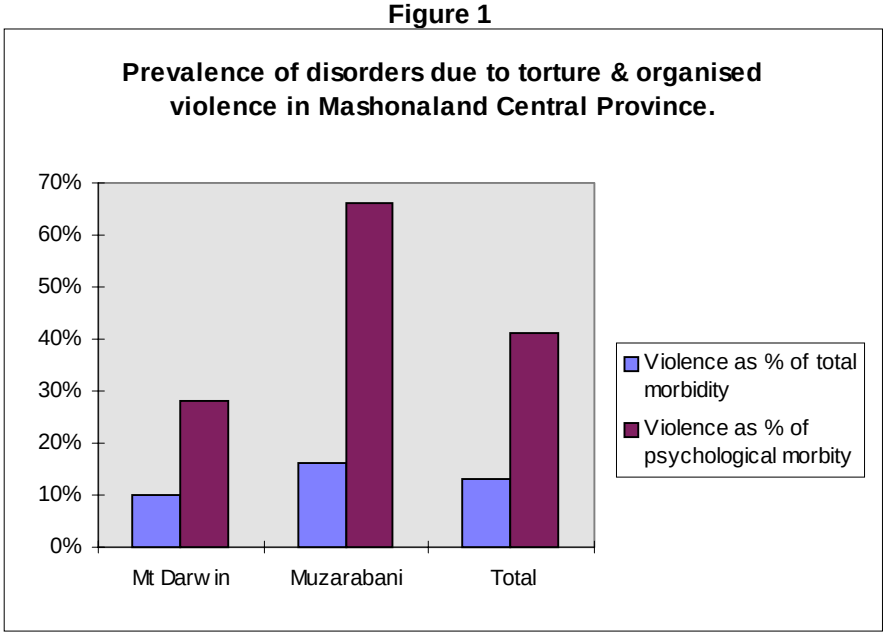
may or may not be a death creates a wide range of problems. African families are compelled by spiritual belief to undertake proper rituals for the burial of the dead, and anything that prevents this happening can leave the family with the expectation of future misfortune. For example, it was frequently observed in the refugee setting that many Mozambican refugees were preoccupied with worries about not having properly buried their dead when they fled into exile. It has also been observed in Zimbabwe that many families were deeply distressed by the non-return of family members from the Liberation War: large numbers of young men and women left home to join the guerrillas in Mozambique, and large numbers never returned. The families have no information about the end of the people, and some have even engaged in lengthy searches to find out what happened, to find where they were buried if they died [Mupinda.1996].

3. Findings from the Liberation War

In order to determine the prevalence of disorders due to torture in the Liberation War, the AMANI Trust carried out a number of studies in the 1990s. The initial work carried out by the AMANI Trust indicated that Common Mental Disorders as well as disorders due to organised violence and torture were common in Mount Darwin District [AMANI.1995], but this work suffered from the flaw that all the data was collected form hospital outpatient attendees who may be a very select group of patients. It was thus decided to conduct a series of point prevalence studies based on prescriptive screening of random primary care patients, and to sample as many of the existing health care facilities in the District. The first study was carried out in 1997, and has been briefly reported elsewhere [AMANI.1997]. A second study was carried out in early 1998 in a neighbouring District - Muzarabani District - and this provided a comparison for Mount Darwin.

There were some differences found in the prevalence rates for disorders due to organised violence and torture [OVT]. As can be seen from Figure 1 below, these differences were marked. OVT was greater in Muzarabani than in Mount Darwin, both as a percentage of total morbidity and of overall psychological morbidity.

Figure 1



Overall, it is evident that disorders due to OVT are a very significant proportion of psychological morbidity. Nearly one adult in ten was suffering a clinically significant psychological disorder due to OVT, and nearly a third of all psychological morbidity was due to OVT. Here it should be borne in mind that this was almost three decades after the original violence, and hence the long-term consequences of OVT cannot be underestimated.

As can be seen from Table 1 below, the survivors from Mount Darwin in Mashonaland Central reported a high frequency of many different types of torture.

Table 1.
Frequency of torture types in Mount Darwin survivors (Amani.1998)

TYPE	Frequency[mean; s.dev]
Physical torture	2.73[1.66]
Deprivation	2.22[1.88]
Impact torture:	**4.99[2.93]**
Sensory over stimulation	0.83[1.28]
Psychological abuse	2.36[1.95]
Psychological torture:	**3.19[2.64]**
Witness torture	2.18[1.99]
Witness executions	0.65[0.99]
Witness total:	**2.83[2.62]**
Total Torture:	8.53[5.55]

Table 2 shows the frequency of the various types of physical abuse reported by the Mount Darwin group. This has much in common with the OVT groups. Beatings are the most common abuse reported, as is commonly found in all studies of torture survivors, and there are a number of other forms that are reported comparatively frequently - exposure, suspension, asphyxiation and electrical shock.

Table 2.
Frequency of physical abuse of Mount Darwin survivors (Amani1998).

Beating	169[51%]
Severe beating	192[57%]
Exposure	42[13%]
Suspension	35[11%]
Unusual posture	28[9%]
Asphyxiation	49[15%]
Burning	24[7%]
Electrical shock	56[17%]
Rape	16[5%]
Other	22[6%]

Rape is always reported at a low frequency, which cannot be taken as indicative that rape was infrequent for several reasons. the most important of these is the very strong reluctance by women to report rape since this can have decidedly detrimental effects on their marital relationship. For example, at least two of the women who reported rape who concerned that their families might learn of their experience, and their concern was that their husbands might divorce them if they suspected that any of the children born during that time might have been products of the rape. Another reason lies in concerns over infertility, and the perception by husbands and families that the infertility might have been caused by the rape.

Deprivation experiences were also commonly reported, as can be seen from Table 3. Not all of the Mount Darwin group were detained during their torture, but, of those who were, various forms of deprivation were reported. Lack of medical treatment is important to note here, for many survivors received no medical care for the injuries sustained during interrogation and torture, and this was complicated by the closure of most hospitals during the latter part of the Liberation War. This has undoubtedly contributed to the chronicity of many of the injuries.

Table 3.
Frequency of Deprivation in Mount Darwin survivors (Amani.1998).

Deprived of food, comfort	122[37%]
Deprived of food, comfort[more than 2-3 days]	124[38%]
Lack of water[more than 48 hours]	41[12%]
Immobilisation, restraint[more than 48 hours]	63[19%]
Lack of sleep[less than 4 hours per night]	89[27%]
Lack of medical treatment	77[23%]
Other	9[3%]

Sensory over stimulation (see Table 4 below) was not commonly reported, which was the finding of previous studies. Sensory over stimulation seems to have been experienced only by those persons who were taken to specialised interrogation centres such as the Selous Scouts Fort in Mount Darwin.

Table 4.
Frequency of Sensory Over stimulation in Mount Darwin survivors (Amani.1998).

Constant noises	55[17%]
Screams, noises	63[19%]
Powerful lights	5[2%]
Constant lighting	6[1.5%]
Special devices	6[1.5%]
Drugs	2[1%]
Other	0

Psychological abuse, however, was reported with a very high frequency, as might have been expected. It is noteworthy that the survivors did not openly report psychological abuse, but the reports were prompted by the assessment process. As can be seen from Table 5, verbal abuse, threats and false accusations were widely reported, with threats against families and simulated executions also being reported with some frequency.

Table 5.
Frequency of Psychological Abuse in Mount Darwin survivors (Amani.1998).

Verbal abuse	218[64%]
Threats	184[54%]
False accusations	163[48%]
Abuse with excrement	17[5%]
Sexual abuse	20[6%]
Threats against family	89[26%]
Simulate execution	79[23%]
Other	9[3%]

Witnessing torture is reported as a separate category from psychological abuse, since witnessing does not necessarily involve the characteristic of being unavoidable. This does not mean that witnessing is less traumatic, and many survivors report the experience of having to watch a loved one undergo violent and painful treatment. As can be seen from Table 6, the frequency of witnessing was very high.

Interestingly, the rate of witnessing electrical torture is low in comparison to the direct experience of this, and this is expected, since virtually all electrical torture would take place at interrogation centres and most witnessing would take place in the community.

Table 6.
Frequency of Witnessing Torture in Mount Darwin survivors (Amani.1998).

Beating	185[56%]
Severe beating	222[67%]
Exposure	51[15%]
Suspension	42[13%]
Unusual posture	68[21%]
Asphyxiation	41[12%]
Burning	74[22%]
Electrical shock	11[3%]
Rape	15[5%]

The frequency of witnessing executions (see Table 7) was much lower than the frequency of witnessing torture. Beatings and shootings were the most commonly reported forms of execution witnessed, which corroborates the reports of independent sources.

Table 7.
Frequency of Witnessing executions in Mount Darwin survivors (Amani.1998).

Beating	72[22%]
Shooting	85[26%]
Stabbing, cutting	12[4%]
Hanging, strangling	9[2.5%]
Burning	17[5%]
Other	16[4.5%]

As can be seen from these findings, the use of torture was widespread during the Liberation War, having severe long-term effects upon the victims. There were many different types of torture used, with psychological torture being particularly common.

Medical examination:
Medical examination of the sample was carried by a doctor with some experience of examining torture survivors. The examination was guided by a protocol developed by the AMANI Trust, but based mostly upon the protocol suggested by Rasmussen in his seminal study of the sequelae of torture (Rasmussen.1990).

On medical examination, only 7% of the patients seen had evidence of anxiety, whilst another 7% showed evidence of depression. The remainder showed no obvious psychological or emotional symptoms.

Scarring due to torture was also not commonly seen, as can be seen from Table 8 below. This is probably not surprising since this is a chronic sample and scarring due to torture is difficult to determine more than two decades after the injury.

Table 8.
Scars attributable to torture (Amani.1998).

Skin(head)	10%
Skin(body)	3%

Skin(extremities)	13%

The detailed medical examination revealed a picture that corroborated the reports of torture given by the clients. As can be seen from Table 9 below, the most commonly identified problems were to do with damage to the vertebral column, which tied in with the reports of severe beatings. The other common problems, to the extremities (fingers, toes, hearing, etc.) and the thorax, were also commensurate with beatings, and, in this sample, with falanga.

Table 9.
Medical examination of Physical Assessment sample (Amani.1998).

Vertebral column	52%
Extremities	29%
Thorax	10%
Skull	7%
Neurological	7%
Abdomen	3%
Genitalia	3%

The general physical condition of the sample was poor, and medical examination indicated that 45% were below average in their nutritional state.

In general, the medical examination did not indicate many obvious problems, but it should be borne in mind that this was clinical examination alone without the support of laboratory or radiological investigations. The sample was also a chronic sample, with most injuries having been inflicted more than two decades previously, which undoubtedly made physical examination more difficult.

4. Findings from the Food Riots

In 1998, the human rights community in Harare swung into action following the many reports of human rights violations, and the Zimbabwe Human Rights NGO Forum (Human Rights Forum) was formed. This group, then a loose alliance of NGOs, provided assistance to detainees, persons complaining of human rights violations and ill-treatment, and produced a report on the riots — ***Human Rights in Troubled Times: An Initial Report on Human Rights Abuses During and After Food Riots in January 1998***[1] **—** which was forwarded to the President and Parliament in support of the request for an independent commission of inquiry. As was stated in the report:

> *The human rights organisations call upon Government to set up, as soon as possible, an independent Commission of Inquiry headed by a High Court Judge to investigate these allegations of human rights violations. In the interests of transparency and accountability the findings of this Commission must be made public. Pending the setting up of such a Commission, the organisations request Parliament to establish its own Committee to look into these allegations and report its findings to Parliament. In conducting these investigations the Parliamentary Committee should enlist the assistance of the Ombudsman's office which now has jurisdiction to investigate allegations of human rights abuses on the part of members of the police, army and prison service. Although the Ombudsman may only investigate when complaints have been made to that office, the proposed Parliamentary Committee would be able to refer some of the complainants to the Ombudsman's office so that their complaints can be investigated by personnel in this office.*

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1 *Zimbabwe Human Rights NGO Forum (1998), Human Rights in Troubled Times: An Initial Report on Human Rights Abuses During and After Food Riots in January 1998.*

Following these inquiries arrangements must be made for compensation to be awarded to all persons found to have suffered human rights abuses without those persons having to bring claims in the courts. Government must also take stern disciplinary action against all those who are proven to have perpetrated human rights abuses to send a clear signal that this sort of misconduct will not be tolerated.

In respect of those who are alleged to have engaged in unlawful violence the law must continue to take its course. However these cases must be dealt with according to the ordinary rules of procedure and evidence which are there to ensure that accused persons receive fair trials. Any cases that were hurriedly processed through the courts in the emotionally charged atmosphere following upon the food riots must be thoroughly reviewed to ensure that no miscarriages of justice have occurred. The sentences in these cases must also be carefully scrutinised to ensure that they were fair and not disproportionate, taking into account the all the relevant factors that have a bearing upon sentence, including the fact that the criminal action may have been an expression of anger and frustration about harsh economic conditions. On the other hand, more deterrent sentences are obviously appropriate for hooligans and criminals who simply took advantage of the troubled situation to commit crimes.

Last but certainly not least, mechanisms must be established to ensure that businesspersons who suffered financial loss as a result of the riots receive compensation or at least soft loans to allow them to re-establish their businesses.

There was no response from either the President or parliamentarians, and thus the Human Rights Forum took the step of lobbying the UN Human Rights Committee at its meeting to consider the implementation by Zimbabwe of the International Covenant on Civil and Political Rights. When the Committee produced its final report in September 1998, it made a strong statement endorsing the call by ZHRNF for an independent commission of inquiry. The UN Committee made two specific recommendations in respect of the Food Riots:

16. The Committee expresses its concern over recent reports of excessive use of force by the police and the army during food riots in 1998. The Committee urges that all cases of alleged excessive use of force committed by members of the police or the army be investigated by an independent and impartial body, that action be taken against those officers found to have committed abuses and that compensation be paid to the victims; the State party should report to the Committee thereon. Intensive training and education programmes in the field of human rights for members of the army and law enforcement officials are recommended. The Committee urges that the list of situations in which the use of lethal force is allowed under domestic law be reduced.

30. The Committee requests the State party to ensure the wide dissemination in Zimbabwe of the Covenant, the State party report and the Committee's concluding observations.

There was been no wide dissemination as requested, and since the Government made no steps to either constitute a commission of inquiry or compensate those who suffered human rights violations, the ZHRNF decided to go ahead and support the request by survivors for civil claims against the Government.

This section deals with the cases that were referred to members of the Zimbabwe Human Rights NGO Forum, and are based on detailed interviews with all the clients. All persons had lengthy interviews with health workers and legal practitioners.
Additionally, medical reports were obtained from medical practitioners and physiotherapists where the clients had seen these personnel. Where possible, witnesses were interviewed and

affidavits obtained from them. All this data was compiled on to a database, and the following results are derived from the database.

All the cases described above were comprehensively assessed as part of their claims for damages. Detailing the psychosocial consequences is important when it is considered that the only other official report on the Food Riots, that issued by the ZRP General Headquarters, made no mention of human rights abuses or even the scale of injuries suffered. The press reports indicated that men, women and children were all affected by the violence, and this is again corroborated by the results of the Mabvuku case studies. As can be seen from Table 10 below, more men than women were affected, and most were young persons (mean age 26.9) as opposed to other groups of survivors. This is not a comment of any consequence however, and it would be expected that current victims would be young. As also might be expected of a young group, there were a large number of single persons and relatively few widowed or divorced persons.

Table 10.
Demographic characteristics of Riots Victims
(HRF. 1999)

GENDER:	
male	30
female	14
AGE:	27.5[9.9]
MARITAL STATUS:	
single	15
married	16
divorced	3
widowed	1
EMPLOYMENT:	
employed	28
unemployed	16

One complaint was brought on behalf of a deceased person, whilst 13 were complaints about injuries due to bullet wounds (see Table 9 below). The majority brought complaints about assaults, some of whom experienced these assaults during detention.

Table 11.
Complaints by victims of Food Riots
(HRF.1999)

Death	1
Bullet wounds	13
Assaults	30
Detention	11

As can be seen from Table 12, most person were injured by members of the Zimbabwe Republic Police, but a large number were also injured by members of the Zimbabwe National Army. Some were injured by more than one branch — uniform branch and support unit of the ZRP — or more than one agency — ZRP and ZNA.

Table 12.
Alleged perpetrators of human rights violations.

(HRF.1999)

Zimbabwe National Army	16
Zimbabwe Republic Police	23
Riot Squad	2
Criminal Investigation Department	1
Support Unit	4

The medical complaints of these survivors were split between those who had been shot — death, bullet wound and amputation — and those who had been assaulted — fracture, pain.

Two people complained that they had lost employment as a result of the injuries sustained. One man, for example, sustained permanent disability — loss of function in his arm — as a result of a bullet wound, and was unable to continue his employment as a driver due to the disability.

Table 13
Medical complaints of victims of Food Riots
(HRF.1999)

Death	1
Bullet wound	10
amputation	1
fracture	4
Pain	12
loss of job	3
epilepsy	1

As regards the deaths, the Zimbabwe Human Rights NGO Forum was only been able to obtain information on the follow-up to one death, that of Kudzai Ndlovu who was shot and killed in Gweru. The public inquest, which was concluded in March 1999, revealed a wholly unsatisfactory situation. The presiding magistrate noted that no satisfactory investigations were conducted in order to reveal the identity of the perpetrator, and went so far as to state that the ZRP in Gweru were actually stifling investigations. He then recommended that the investigations should be taken over by an independent team of investigators from a different town. This is clearly at variance with the assertions of Superintendent Bvudzijena and the ZRP's own report.

4.1 Torture during the Food Riots

As indicated above, torture can be defined according to various different definitions, the most common of which are the definitions contained in the UN Convention Against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment and Punishment (UN.1984) and the Declaration of Tokyo (WMA.1975). The latter has remained the most complete statement about torture yet produced by the medical profession. As the WMA definition states:

> *For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason. (World Medical Association,1975)*

According to this definition, a very large number of persons experienced torture during the Food Riots. Table 14 below shows the reported frequencies of the various torture types reported by the survivors seen by the Zimbabwe Human Rights NGO Forum, and examined by the AMANI Trust.

Table 14.
Mean frequency of Torture types reported by Food Riots victims
(HRF.1999)

Physical abuse	1.3
Deprivation	0.7
IMPACT TORTURE	2.02
Sensory over stimulation	0.21
Psychological abuse	1.5
PSYCHOLOGICAL TORTURE	1.7
Witnessing assaults	1.2
Witnessing executions	0
WITNESSING TORTURE	1.2

The group did not report frequencies of torture as high as previous groups (AMANI.1998), which again is unsurprising since most had only one encounter with the Police or the Army. Impact Torture was reported much more frequently than other forms, and, of the forms of Impact Torture, beatings were the most frequently reported. Psychological abuse was reported with the greatest frequency. One important factor in the pattern of abuse is that most of this group were tortured outside of detention.

Table 15.
Unconsciousness reported by Food Riots victims
(HRF.1999)

>30 minutes	30-60 minutes	60-120 minutes	<120 minutes
7	1	1	1

A very high proportion (24%) of the group reported unconsciousness, but most of these reported unconsciousness of less than 30 minutes. For the majority of those reporting unconsciousness, this was associated with gunshot wounds, but two members reported unconsciousness following assaults. Unconsciousness is important to identify, both because of its association with long-term disability and its status as an indicator of the severity of the assault.

Table 16
Symptoms reported by Food Riots victims on the Present Health Status Questionnaire(PHSQ)
(HRF.1999)

PHSQ(tot)	PHSQ(psy)	PHSQ(phys)	PHSQ(sleep)
13.7	5.8	6.7	2.3
6.9	4.2	3.6	2.3

The group as a whole reported very high numbers of symptoms after the alleged torture. The mean number of symptoms reported was 13.7[s.dev 6.9], and this was a mixture of both psychological and physical symptoms. People with ordinary psychological disorders have been shown to present with high numbers of symptoms — about 3 according to most Zimbabwean studies[2], and this group had a considerably higher number of symptoms. This was probably due to the combination of physical and psychological injuries.

The scores obtained from the Self-Reporting Questionnaire (SRQ-8) and the Harvard Trauma Scale (HTS) additionally show that this group had experienced psychological problems as a consequence of their alleged torture. The SRQ-8 is a psychiatric screening instrument, and all scores in excess of 4/8 are strongly indicative of clinically significant psychological disorder. Fifteen (36%) members of the sample reported scores in excess of 4/8, which is lower than other Zimbabwean samples, but is undoubtedly due to the fact that most people experienced only a single experience.

The sample reported more experiences of trauma than witnessing or hearing stories on the Harvard Trauma Scale. Only 7 (47%) persons of the clinically disordered group showed signs of PTSD, but this was a much higher percentage than other Zimbabwean studies, and undoubtedly reflects the acute nature of the psychological distress. PTSD would be more strongly expected as an immediate consequence of OVT than other forms of disorder.

The victims from the Food Riots in 1998 were different in many ways to the sample from the 19870s War of Liberation. In most respects their treatment was less severe than those from

[2] **See** *HALL, A., & WILLIAMS, H. (1987)(a), Hidden psychiatric morbidity. Part I: Study of prevalence in an outpatient population at Bindura Provincial Hospital, Central African Journal Of Medicine., 33, 239; REELER,A.P., WILLIAMS,H., & TODD,C.,H.,(1993), Psychopathology in Primary Care patients: A four-year study in rural and urban settings, Central African Journal Of Medicine, 39, 1-8; PATEL, V., TODD, C., WINSTON, M. ET AL (1997), Common mental disorders in primary care in Harare, Zimbabwe: associations and risk factors, Brit.J.Psychiat., 171, 60-64.*

the Liberation War, and was confined to a single episode of torture or injury due to gunshot wound. However, it is significant that they clearly suffered from the experience and many were psychologically disturbed by the experience. The data did support the claims that torture had been inflicted and that gross human rights violations had taken place. This report has subsequently been validated by the results of the court cases that have taken place, where the majority of the claims have been upheld by the courts and damages awarded. In some of the cases, the judges have made very strong statements about the use of torture and indiscriminate and irresponsible use of firearms.

5. Victims from the 2000 Parliamentary Elections

During the 2000 Parliamentary Elections in Zimbabwe, there were a very large number of reports made of gross human rights violations being perpetrated by the supporters of the Zanu(PF) government. These reports were made by local observer groups such as the Human Rights Forum, the Zimbabwe Election Support Network (ZESN), and the Zimbabwe Civic Education Trust (Zimcet), as well as by international human rights organisations and election observer groups. A number of the victims of OVT were referred to the AMANI Trust for medical assistance. This has been documented in detail in a number of reports dealing with the Parliamentary Elections[3], and it is not our intention to summarise the enormous detail relating to human rights violations and electoral irregularities here. Additionally, many of the issues related to the psychological distress suffered by the victims and the issues related to some of them testifying in the Zimbabwe High Court to their experiences have been described elsewhere[4]. Here we will confine ourselves to some quantitative observations about the victims from the Parliamentary Elections. This summary is based upon the victims seen by the Amani Trust.

Firstly, the sample was largely male (73%), and most were married. In contradistinction to the sample from the Liberation War most (65%) were employed, and, since the majority were supporters of the Movement for Democratic Change (MDC), this probably reflects bias to the urban and educated group frequently associated with the MDC. AS can be seen from Table 17 below, the perpetrators, at least for this sample, were drawn from three main groups. Surprisingly, there was no mention of either the Zimbabwe Republic Police or the Zimbabwe Republic Army, groups that have been mentioned in other reports, albeit with less frequency than the three groups mentioned here.

Table 17.
Perpetrators during the 2000 Parliamentary Elections.

Perpetrators	Percentage
CIO	4%
War Veterans	35%
Zanu(PF) supporters	61%

As can be seen from Table 18, relatively high rates of torture are reported. The mean number of different torture types experienced was high, and much more like the survivors from the Liberation War than the Food Riots. Physical abuse and psychological torture were the most common categories, but the witnessing of torture was also common.

[3] **See** *AMANI (2002), Neither Free nor Fair: High Court decisions on the petitions on the June 2000 General Election, HARARE: AMANI TRUST; AMANI (2002), Organised Violence and Torture in the Bye-Elections held in Zimbabwe during 2000 and 2001, HARARE: AMANI TRUST.*

[4] **See** *AMANI (2002), Heroism in the Dock: Does testifying help victims of organised violence and torture? A pilot study from Zimbabwe, HARARE: AMANI TRUST; AMANI (2002), "At the boiling point of the pain". Report of a pilot study examining the efficacy of psychotherapy for torture survivors, HARARE: AMANI.*

Table 18.
Types of torture reported during the 2000 Parliamentary Elections.

Physical abuse	1.8 (1.3)
Deprivation	0.44(0.7)
IMPACT TORTURE	2.3(1.9)
Sensory over stimulation	0.04(0.2)
Psychological abuse	2.1(1.5)
PSYCHOLOGICAL TORTURE	2.12(1.5)
Witnessing assaults	0.92(1.1)
Witnessing executions	0.4(0.8)
WITNESSING TORTURE	1.3(1.3)
TOTAL TORTURE	5.7(3.8)

There were significant numbers of the victims with clinically significant psychological disorders (46%). The mean SRQ-8 score (4.1; s.d: 1.8) was higher than that obtained from the victims of the Food Riots, which is unsurprising in view of the finding that the victims from the Parliamentary Elections experienced more severe torture and multiple occasions of torture. A high proportion (39%) of the victims reported periods of unconsciousness, which was all associated with physical torture, and beatings in particular.

Table 19.
Unconsciousness reported by victims from 2000 Parliamentary Elections.

>30 minutes	30-60 minutes	60-120 minutes	<120 minutes
3	5	0	3

Here we should comment that this sample was drawn mainly from victims in urban areas and from the communal lands, and another study conducted by the AMANI Trust, in internally-displaced commercial farm workers, has shown a very much worse profile[5]. In this most recent study, it was found that 71% had suffered a recent experience of torture, with 65% having another previous experience. 59% had had another adult family member witness their torture, with 55% having had a child witness the same. In this population, over 80% had clinically significant psychological disorders, which is far and away the highest prevalence rate obtained din any Zimbabwean study.

Thus, there may be important differences between victims from the commercial farms and other populations in the current epidemic of organised violence and torture, and there remains a pressing need for detailed study of the problem, with the development of accompanying helping services.

6. Overview

As will hopefully be seen from this admittedly sketchy summary, organised violence and torture have been a common feature of the Zimbabwe political landscape of the past three decades. This review does not include the Gukurahundi period, as there are yet to emerge any good clinical studies of this period, although there are a plethora of human rights reports and reports of various types of interventions with the survivors of the Gukurahundi. However, taken together, the overview is one that must cause considerable concern. Some general points can be made here.

Firstly, there is continuous evidence of the use of systematic torture over the decades, as well as obvious evidence of organised violence, for what better term can be used to describe civil war than “organised violence”. However, the use of torture is very serious matter, and is now proscribed by a large number of international conventions and covenants. There are no times or situations during which the use of torture can be justified, but this does not seem to be a

[5] **See** *AMANI (2002), Preliminary Report of a Survey on Internally Displaced Persons from Commercial Farms in Zimbabwe, HARARE: ZIMBABWE.*

lesson that has been learned in Zimbabwe. When it is additionally realised that Zimbabwe usually deals with this understanding through the use of impunity, the magnitude of this problem becomes clear.

Secondly, the numbers of people affected over the years is growing, and may now reach hundreds of thousands. It seems that the term “epidemic” is warranted, and we have previously commented that the epidemic due to organised violence and torture may rival the HIV/AIDS epidemic. This is a crucial point to understand. The most severe and persistent consequences of torture are psychological, and, as we have demonstrated in our work with the oldest living survivors of our many epidemics – those from the Liberation War – psychological disorders may persist for decades. This is not merely to emphasise the need for treatment, for it is also clear that treatment may allow many survivors to cope better, but there is no strong evidence that we can cure the after-effects of torture. The point here is to stress prevention rather than cure, or prevention in addition to cure.

This is our third point. Prevention means changing the ways in which we resolve our political disagreements, for it is abundantly clear that all of these victims are produced by an inability to resolve political dispute or to maintain political through the use of force. As will be seen in the evidence to follow, the current epidemic is wholly related to political problems, to the desire to maintain political power through the use of force. In reality, in Zimbabwe, the more things change, the more they stay the same; at least this seems true for the victims of torture. It cannot be said that we do not know these things any more, and the data accumulated by the AMANI Trust over the past decade provides strong testimony that we have not heard the voices of the victims clearly enough. It is sad, therefore, that we must produce again a new report in order that the victims’ voices be heard.

7. Torture related to the 2002 Presidential Election

Amani Trust is a non-partisan organisation that is prepared to assist any victims of organised violence whatever their political affiliation. Although relatively few ruling party supporters have sought medical assistance from Amani, it has helped several of ruling party supporters. Apart from negative government perceptions of Amani, another reason why not many ruling party supporters have not approached Amani may be that these persons are often employed by the state and therefore have easier access to state assisted health care.

7.1 Background to the Presidential Election

State organized violence increased following the rejection of the Government sponsored constitution in the referendum at the beginning 2000. The violence was initially sporadic and confined to one or two areas at a time but as the 2000 parliamentary elections approached, it became more intense and widespread. The state trained and deployed more people in an effort to control perceived supporters of the newly formed opposition. At first the beatings were random and the perpetrators used crude weapons such as sticks and logs. Later the persons perpetrating the violence became more organised. They started to make use of weapons such as batons, whips and bicycle chains. The use of torture techniques such as electrical shocks, burning and mock executions became more prevalent.

By the time the 2000 parliamentary elections took place there were very few parts of Zimbabwe, urban or rural, that had not been subjected to some form of state organized violence. The actual prevalence of violence prior to the 2000 elections was hard to estimate, as many people were too frightened to report the violence. People were unable or unwilling to report the incidents to the police. In a disturbingly large number of cases, the police or the CIO were named by the victims as either being involved in the torture or reluctant to prevent or stop the ill treatment.

Many people who were assaulted were unable to afford medical help from the health services and their injuries were thus not documented by medical personnel. Since methods of torture are designed not to leave permanent scarring, this meant that by the time the victims were able to seek medical help, there were few visible scars. Many of the residual injuries seen in were more difficult to establish as directly related to the torture that they had received.

However, complaints such as chronic backache secondary to myofibrositis from soft tissue injuries, joint pain as a consequence of being restrained in abnormal positions, and foot pain due to falanga were prevalent. Many of the victims had suffered significant psychological trauma and were suffering from a post traumatic stress disorder. Therefore careful interview technique and examination was required in order to verify the narratives given by the patient. The findings were previously reported in several publications of the Human Rights Forum, and are summarized here.

After the June 2000 parliamentary elections, it was established that 39 constituencies had sufficient reasons to challenge the results in the High Court, and a majority of challenges were based on the amount of violence that had occurred in the time preceding the elections. People who had suffered physical beatings and torture were brought to Harare as witnesses, and for many of these victims, it was the first time they were able to report what had happened to them and to seek medical help for their physical and psychological injuries. Amani Trust was involved with the documentation and in organizing treatment for these victims. The Trust was also responsible for providing the necessary counselling prior to testifying in court, and debriefing the victims afterwards. After the June 2000 Parliamentary elections it was hoped that the violence would subside, but as the election petitions and by-elections occurred in the subsequent months, the violence kept appearing, concentrated in the constituency in which there was a direct challenge to the ruling party.

Because Amani was increasingly concerned by the evidence of systematic torture, various systems were set up in order to meet the specific medical requirements of victims of organized violence and torture. Initially funding support for the medical treatment was difficult to find, but as more evidence of organized torture and violence was revealed, the donor community was willing to fund the medical requirements of the victims. This meant that Amani was able to establish a comprehensive programme for victims of organized violence and torture. In the beginning all the medical services were rendered to patients only when they reached Harare, but this often meant considerable delays, while transport was arranged, and messages sent requesting help. (Many of the victims and their families were and are unable to move freely within their communities.) Therefore a network of health services was set up throughout the country so that victims were able to receive medical attention within a shorter period of time. This also meant that the injuries were seen and documented by medical personnel while still fresh, and therefore more accurate reports could be recorded.

Many patients also required physiotherapy. Amani established a dedicated physiotherapy service, using physiotherapists with specific training in treating and rehabilitating injuries peculiar to torture such as falanga. Other physiotherapists were also utilized when patients required a more specific therapy as requested by the treating surgeons. While the patients were undergoing treatment, they were provided with accommodation and transport to and from appointments, as the majority of the patients were from centers outside Harare.

Counselling for patients was provided on different levels. The initial interview and documentation of injuries marked the start of therapy, and initial assessment of the patient's mental state. From this assessment, the patient was either referred for counseling by appropriately trained trauma counsellors, or to a psychiatrist, for neuro-psychiatric assessment and treatment.

A pilot study was conducted by a group of clinical psychologists, to establish the specific needs of victims of organized torture and violence, and a comprehensive programme to develop counseling services in the affected communities is being established. This is an important component of rehabilitation, because as shown in previous studies by Amani Trust, communities and families that have been subjected to violence, and that have had no access to counseling services and redress, have more social dysfunction, and chronic illness than other communities.

With the development of these concurrent comprehensive programmes for victims, it became easier for Amani to reach and treat victims of organized violence, and to monitor the levels and methods of perpetration of violence in the communities.

During 2001 reports were released from the Human Rights NGO Forum on a monthly basis, using the data gathered both from Amani Trust and other sources, and tracking all the components of the violence, such as the area, perpetrators, methods of torture used etc.

From this information, a number of facts emerged:

1. *It was clear that more systematic forms of torture were being employed;*
2. *It was clear that there was wide spread geographical spread in the of various forms of torture;*
3. *It was clear that the perpetrators were increasingly members of the 'youth militia;'*
4. *It was clear that torture was increasingly being inflicted at the 'bases' of the youth militia*.

When the violence first started, most victims were beaten at their homes or local gathering point, but by January 2002, when the violence rose exponentially in anticipation of the presidential elections, nearly 50% of victims gave a story of abduction to a specific 'base.' When they were detained for up to ten days and then systematically tortured using well known methods of torture such as whipping, beating, slapping across the ears to rupture the ear drums, falanga, burning, attempted drownings, and sexual assault. It was increasingly disturbing to record the increasing frequency of rape as a method of torture. This was particularly serious in view of the life long implications of HIV infection. There were recorded incidents of the abductees being used as forced labour, and being denied food, shelter and medical attention. Many victims were cautioned against seeking medical help or making a report, and a number of victims were assaulted on more than one occasion.

After the results of the presidential elections were announced it was expected that the violence would decrease as had happened after the Parliamentary elections in 2000. Instead the violence intensified and became even more targeted. All officials involved in the electoral process from all contesting parties were required by law to have their names and identification particulars published in the local press, and after the elections. Such opposition officials were actively sought by the youth militia, frequently assisted by state security services, and then abducted and tortured. Many of these people are still not able to return to their homes and are living in Zimbabwe as refugees, or internally displaced people.

a. The Evidence of Torture

This section summarizes the information relating to 180 cases of torture. The cases themselves will be given in an accompanying dossier which will be submitted to the African Commission on Human and People's Rights, the UN Commission on Human Rights, and a number of the UN Special Rapportours on Torture.

The 180 patients presented in the dossier represent the patients who sought medical help from Amani, from January 2002, when the violence noticeably increased. They sought help from Amani either because of their injuries or because they were unable to get help elsewhere. These patients were all assessed by the clinical team during the course of their treatment. It is by no means a dossier of all the victims of organized violence in the five month period around the elections. Many people did not seek medical help because of fear, and many patients did not reach Harare. Amani has over 570 documented cases over the same period that were seen in other medical facilities around the country, which gives a total 750 people requiring medical attention over the first five months of 2002 because of their perceived political beliefs. Over the week around the elections in March 9 people required hospitalization for their injuries from torture in Harare, and there were more than 10 in other centers. It should be noted here that there were virtually no such reports during the 2000 Parliamentary Elections. As indicated above the violence did not cease after the Presidential election , and, over the month of March 70 people sought medical help in Harare, with over 120 in other centers.

As can be seen from Table 20 below, the injuries associated with torture were characteristic of systematic torture. Beatings were clearly the most common form of torture, but other types

were also reported. It is significant that falanga was commonly reported (19%), as this has not been a common form in previous decades and has only recently become widespread in its use. A large number of torture victims (19%) required hospital admission due to the severity of their injuries, with many requiring either special surgery or orthopedic treatment.

Table 20.
Percentage occurrence of various forms of injury associated with torture.

INJURY	% OCCURRENCE
Beatings	97%
Falanga	19%
Requiring hospital admission	19%
Skeletal injuries	7%
Burns	7%
Stab wounds	6%
Ruptured ear drums	5%

In Mashonaland East there were three instances of branding of victims, all done by the same gang, where the initials of the opposition party were carved into the victim's back. One of these cases was widely reported at the time.

It is evident from the injuries themselves that these were due to torture and not to injuries sustained during violent fights. The beatings were mainly confined to the back and the buttocks, and were generally consistent with the victims allegations that they had been compelled to lie down or forced to withstand the beatings. Falanga, of course is impossible to inflict without compelling the victim to remain still or by holding the victim still.

Rupturing of the eardrums rarely occurs during fighting since it requires percussive blows to the ears. It is not a blow per se that causes the injury, but it is the deliberate percussion (usually with a cupped hand) that causes the rupture.

The medical evidence clearly supports the testimony of the victims, and in many cases is corroborated by the statements of family members. Furthermore, the evidence from these cases conforms to the reports of other independent investigations. It is also important to note that victims reported more than one form of torture.

The perpetrators are generally those identified as those commonly reported in earlier reports.

Table 21.
Perpetrators identified by victims.

Perpetrator	Percentage
Zanu(PF) supporters	46%
Youth militia	29%
Zimbabwe Republic Police	12%
MDC	5%
War veterans	4%
Zimbabwe National Army	2%
Unknown	2%

It is important to note that not all the violence in Zimbabwe is perpetrated by the state or ruling party supporters. However the percentage of violence perpetrated by the opposition MDC is relatively small, and furthermore the evidence available to the Amani Trust does not indicated the use of systematic torture.

The significant change observed during the Presidential election is the increased number of cases in which the youth militia are implicated. This has been noted in many other recent reports. There seemed to be significantly higher percentage of cases involving the Zimbabwe Republic Police, and much of this seemed to occur during the post-election period when there was a purge on opposition party polling agents and election officials.

7.2 Conclusions

In many ways the individual cases reported in the accompanying dossier will speak for themselves, but they cannot however give any estimate of the prevalence of torture during 2002. This evidence thoroughly supports the conclusion that systematic torture is being used in Zimbabwe, although there has been a significant decline in the past month.

The evidence also suggests that torture techniques have been taught to various groups in Zimbabwe. This is clearly suggested by the increased use of falanga, as well as by the types of beatings inflicted and the instruments employed. All of the injuries suggest the deliberate infliction of pain and suffering with an intention not to kill or maim, but rather an intention to punish or terrify. And this was done in an attempt to influence an election: the victims were all told that their political associations or beliefs were unacceptable. The victims were frequently told to give up their associations and beliefs and were frequently told that their political party would not be allowed to win the Presidential election.

This all conforms to the definition of torture contained in the UN Convention Against Torture. The Amani Trust has previously deprecated this situation, and in a recent report made a number of recommendations. We can only reiterate these recommendations:

1. ***The international community should carry out independent, impartial investigations into human rights violations and should work with Zimbabwean civil society in such investigations;***
2. ***Government, regional and international action is needed to reform the Zimbabwe Republic Police in order to promote the accountability and effectiveness of the police;***
3. ***Government, regional and international action is needed to promote the Zimbabwe judiciary's independence and effectiveness;***
4. ***The Zimbabwean government should review legislation to repeal or amend those laws that are unconstitutional or violate human rights;***
5. ***The Zimbabwe government should ratify the Convention Against Torture with alacrity.***

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